



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 03-12	2. STATE Kansas
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Medicaid	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE June 30, 2003	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.201, 42 CFR 442.10		7. FEDERAL BUDGET IMPACT: a. FFY 2003 \$3,000,000 b. FFY 2004 \$9,000,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: See Attached		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): See Attached	
10. SUBJECT OF AMENDMENT: Methods and standards for establishing nursing facility payment rates.			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Janet Schalansky, Secretary Social & Rehabilitation Services Docking State Office Building 915 SW Harrison, Room 651S Topeka, KS 66612-2210	
13. TYPED NAME: Janet Schalansky			
14. TITLE: Secretary of Social & Rehabilitation Services			
15. DATE SUBMITTED:			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 06/26/03		18. DATE APPROVED: July 28, 2004	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUN 30 2003		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: DENNIS G. Smith		22. TITLE: DIRECTOR, CMSO	
23. REMARKS:			

KANSAS MEDICAID STATE PLAN

Form CMS 179
State Plan TN-MS-03-12
Attachment 4.19D Part I:
Nursing Facility

Number of Plan Section:

Number of Superseded Plan Section:

Attachment 4.19D, Part I:

Subpart C, Exhibit C-1, pages 1-15

Subpart C, Exhibit C-1, TN-MS-02-06 pages 1-21

Subpart C, Exhibit C-2, pages 1-6

Subpart C, Exhibit C-2, TN-MS-02-06, pages 1-8

Subpart C, Exhibit C-3, pages 1-3

Subpart C, Exhibit C-3, TN-MS-02-06, pages 1-3

Subpart C, Exhibit C-4, pages 1-2

Subpart C, Exhibit C-4, TN-MS-02-06, pages 1-2

Subpart C, Exhibit C-5, pages 1-3

Subpart C, Exhibit C-5, TN-MS-02-06, pages 1-3

Subpart D, page 1

Subpart D, TN-MS-02-06, page 1

Subpart E, pages 1-3

Subpart E, TN-MS-02-06, pages 1-10

Subpart H, pages 1-2

Subpart H, TN-MS-99-01 (Reserved)

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Part I

Subpart C

Exhibit C-2

Page 1

INFLATION FOR REPORT YEAR ENDS PRIOR TO 07/01/03
EFFECTIVE 07/01/03

REPORT YEAR END (RYE)	MIDPOINT OF RYE	MIDPOINT OF RYE INDEX	MIDPOINT OF RATE PERIOD	MIDPOINT OF RATE PERIOD INDEX	HISTORICAL INFLATION FACTOR % *
12-00	06-00	1.291	12-02	1.415	9.605%
12-01	06-01	1.358	12-02	1.415	4.197%
01-02	07-01	1.369	12-02	1.415	3.360%
02-02	08-01	1.369	12-02	1.415	3.360%
03-02	09-01	1.369	12-02	1.415	3.360%
04-02	10-01	1.380	12-02	1.415	2.536%
05-02	11-01	1.380	12-02	1.415	2.536%
06-02	12-01	1.380	12-02	1.415	2.536%
07-02	01-02	1.389	12-02	1.415	1.872%
08-02	02-02	1.389	12-02	1.415	1.872%
09-02	03-02	1.389	12-02	1.415	1.872%
10-02	04-02	1.396	12-02	1.415	1.361%
11-02	05-02	1.396	12-02	1.415	1.361%
12-02	06-02	1.396	12-02	1.415	1.361%
01-03	07-02	1.405	12-02	1.415	0.712%
02-03	08-02	1.405	12-02	1.415	0.712%
03-03	09-02	1.405	12-02	1.415	0.712%
04-03	10-02	1.415	12-02	1.415	0.000%
05-03	11-02	1.415	12-02	1.415	0.000%
06-03	12-02	1.415	12-02	1.415	0.000%

* = (Midpoint of rate period index / Midpoint of rye index) -1

JUL 28 2004

TN# MS-03-12 Approval Date _____ Effective Date June 30, 2003 Supersedes TN# MS-02-06

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Page 2

COST CENTER LIMITATIONS EFFECTIVE 07/01/03

<u>COST CENTER</u>	<u>UPPER LIMIT</u>
Operating	\$20.32
Indirect Health Care	\$33.35
Direct Health Care	\$61.78 *
Real and Personal Property Fee	\$6.11

* = Base limit for a facility average case mix index of .9197

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INCENTIVE FACTORS EFFECTIVE 07/01/03

Level	Percentile Range		Per Patient Day Range		Incentive
	Low	High	Low	High	Factor
NF	-0-	30th	\$ -0-	14.97	\$.50
	31st	55th	14.98	17.73	0.40
	56th	75th	17.74	20.79	0.30
	76th	100th	20.80	above	-0-

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OWNER/RELATED PARTY SALARY LIMITATIONS

EFFECTIVE 07/01/03

Job Classification	Salary Range**	Bed Capacity					
		0-59	60-120	121+	0-99	100	Any Size
Administrator	23	31,470					
	28		40,186				
	31			46,509			
Co-Administrator	19	25,896					
	22		30,014				
	24			33,030			
Accountant II	24						33,030
Attorney II	31						46,509
Bookkeeper	15						21,320
Secretary II	15						21,320
Gen. Maint. & Repair Tech II	17						23,504
Physical Plant Supervisor I (1-2 Fac.)	23						31,470
Physical Plant Supervisor II (3+ Fac.)	25						34,715
Cook	11						17,534
Food Service Supervisor II	17						23,504
Housekeeping/Laundry Worker	9						15,891
Director of Nursing (RN III)	25				34,715		
Director of Nursing (RN IV)	28					40,816	
Registered Nurse (RN II)	22						30,014
Licensed Practical Nurse (LPN)	18						24,669
LPN Supervisor	20						27,206
Health Care Assistant (Nurse Aides)	12						18,429
Mental Health Aide	12						18,429
Physical Therapist II	27						38,230
Physical Therapist Aide	13						19,365
Occupational Therapist II	26						36,462
Speech Pathologist/Audiologist I	26						36,462
Activity Therapy Tech.	14						20,280
Activity Therapist I	22						30,014
Social Worker	22						30,014
Medical Records Administrator	24						33,030
Medical Records Technician	19						25,896
Central Office Staff (3+ Facilities)							
Chief Executive Officer	36						59,363
Chief Operating Officer	34						53,872
All Other Chief Officers	31						46,509
* License/Registration/Certificate Requirement							
** Step 5 of the salary range has been used to set the limits.							

JUL 28 2004

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KANSAS

PAMELA JOHNSON-BETTS, SECRETARY

DEPARTMENT ON AGING

KATHLEEN SEBELIUS, GOVERNOR

June 20, 2003

«ADMIN_NAME», Administrator
«FAC_NAME»
«FAC_ADDRES»
«CITY», KS «ZIP»

Provider #: 104«PROV_NUM»01

Dear «ADMIN_NAME»:

We forwarded the per diem rate shown on the enclosed Case Mix Payment Schedule for the first quarter of state fiscal year 2004 to our fiscal agent, Electronic Data Systems of Kansas. The rate will become effective June 30, 2003 but because the payment system can not accommodate an effective date other than the first of a month a lump sum settlement will be calculated for June 30, 2003. That settlement will be applied to a future remittance advice once accurate service history for June 30, 2003 has been compiled (anticipated during October 2003).

The Kansas Department on Aging (KDOA), administers the Medicaid nursing facility services payment program on behalf of SRS. The rate was calculated by applying the appropriate Medicaid program policies and regulations to the cost report (Form MS 2004) data shown on the enclosed payment schedule.

For each nursing facility and nursing facility for mental health, the per diem rate for care shall not exceed the rate charged for the same type of service to residents not under the Kansas medical assistance program. If the private pay rate indicated on the agency register is lower, then the Kansas medical assistance program rate, beginning with its effective date, shall be calculated as follows: If the average Medicaid case mix index is greater than the average private pay/other case mix index, the Kansas medical assistance program rate shall be the lower of the private pay rate adjusted to reflect the Medicaid case mix index or the calculated Kansas medical assistance program rate. If the average Medicaid case mix index is less than or equal to the average private pay/other case mix index, the Kansas medical assistance program rate shall be the average private pay rate. The effective date of the private pay rate in the registry shall be the later of the effective date of the private pay rate or the first day of the following month in which complete documentation of the private pay rate is received by the agency. SEE KANSAS ADMINISTRATIVE REGULATION (KAR) 30-10-18(b).

If you disagree with the rate in the attached payment schedule, you have the right to request a fair hearing appeal in accordance with K.A.R. 30-7-64 et seq. Your written request for such an appeal should be delivered to or otherwise mailed so that it is received by the Department of Administration, Office of Administrative Hearings, 1020 South Kansas Ave, Topeka, Kansas 66612-1311 within 30 days from the date of this letter. (Pursuant to K.S.A. 77-531, an additional three days shall be allowed if this notice letter is mailed rather than hand delivered.) Failure to timely request or pursue such an appeal may adversely affect your rights on any related judicial review proceeding.

If you have questions regarding the Medicaid rate, other than those on desk review adjustments, write to Chris Chase or call her at (785) 296-0703. She can also be reached via electronic mail at ChrisC@Aging.state.ks.us. For questions concerning desk review adjustments please contact Barbara Parkison, Audit Manager, at (785) 296-2535 or by email at BarbaraP@aging.state.ks.us.

Sincerely,

Dave Halferty, Senior Manager
Nursing Facilities and CARE Programs
Program and Policy Commission

DH:ckc
Enclosures

NEW ENGLAND BUILDING, 503 S. KANSAS AVENUE, TOPEKA, KS 66603-3404
Voice 785-296-4986

Fax 785-296-0256

<http://www.agingkansas.org/kdoa/>



KANSAS

JANET SCHALANSKY, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

SOCIAL AND REHABILITATION SERVICES
Management Operations/Accounting and Contracts Team
Division of Health Care Policy

June 20, 2003

«ADMIN_NAME», Administrator
«FAC_NAME»
«FAC_ADDRES»
«CITY», KS «ZIP»

Provider #: 154«PROV_NUM»01

Dear «ADMIN_NAME»:

We forwarded the per diem rate shown on the enclosed Case Mix Payment Schedule for the first quarter of state fiscal year 2004 to our fiscal agent, Electronic Data Systems of Kansas. The rate will become effective June 30, 2003 but because the payment system can not accommodate an effective date other than the first of a month a lump sum settlement will be calculated for June 30, 2003. That settlement will be applied to a future remittance advice once accurate service history for June 30, 2003 has been compiled (anticipated during October 2003).

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If you disagree with the rate in the attached payment schedule, you have the right to request a fair hearing appeal in accordance with K.A.R. 30-7-64 et seq. Your written request for such an appeal should be delivered to or otherwise mailed so that it is received by the Department of Administration, Office of Administrative Hearings, 1020 South Kansas Ave, Topeka, Kansas 66612-1311 within 30 days from the date of this letter. (Pursuant to K.S.A. 77-531, an additional three days shall be allowed if this notice letter is mailed rather than hand delivered.) Failure to timely request or pursue such an appeal may adversely affect your rights on any related judicial review proceeding.

If you have questions regarding the Medicaid rate, other than those on desk review adjustments, write to me or call at (785) 291-3202. For questions concerning desk review adjustments please contact Barbara Parkison, Audit Manager, at (785) 296-2535 or by email at BarbaraP@aging.state.ks.us.

Sincerely,

Gayla Carr
Management Systems Analyst

Enclosures

DOCKING STATE OFFICE BUILDING, 915 SW HARRISON ST., ROOM 10th Floor S, TOPEKA, KS 66612-1570

Voice 785-291-3202 Fax 785-368-6228 www.srskansas.org

KANSAS MEDICAID STATE PLAN

Attachment 4.19D
Part I
Subpart D

Methods and Standards for Establishing Payment Rates
Skilled Nursing and Intermediate Care Facility Rates
(NFs and NFs-MH)

Therapeutic Mental Health Treatment Pass-Through
for Special Level of Care Facilities

This provision allows for the pass-through of therapeutic mental health treatment expenses to nursing facilities for mental health that meet certain criteria.

Criteria for Determining Eligible Providers:

Only special level of care facilities classified as nursing facilities for mental health are eligible for this pass-through. A nursing facility for mental health is defined as:

1. A nursing facility licensed by the State of Kansas; and
2. Certified to participate in Medicaid by the Department of Social and Rehabilitation Services that, pursuant to 42CFR 435.1009, the Center for Medicare and Medicaid identifies as an institution for mental disease.

A nursing facility for mental health will be eligible for the increased rate if:

1. Its established rate using the base year methodology is less than the rate it received during the preceding year, and
2. It demonstrates it is providing specific additional amounts of mental health treatment services above the amount provided during the base year.

Determination of Pass-Through Amount for Eligible Providers:

The per diem rate for a nursing facility for mental health may be increased from the established rate based on documented additional costs associated with providing therapeutic mental health treatment services above the amount provided in the base year which are not otherwise covered by the established rate. The increased amount provided the eligible nursing facility for mental health will be the per diem amount that the facility can document is attributable to increased therapeutic mental health treatment. The increased amount shall not exceed the difference between the allowable per diem costs on the most recent cost report and the base year cost report before inflation. Only costs from indirect and direct health care cost centers shall be included in the per diem calculations. No per diem increases shall be based on increased administrative, property, or plant operating costs. All per diem amounts used in the determination of the pass-through add-on shall be calculated by dividing the expenses reported on the cost report by the actual residents days provided during the cost report period.

KANSAS MEDICAID STATE PLAN

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Part I

Subpart E

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Method and Standards for Establishing Payment Rates:
Nursing Facilities

Rates When Two Or More Nursing Facilities Merge Under One License

The Kansas Department of Health and Environment (KDHE) instituted a policy wherein if two nursing facilities meet certain policy criteria, KDHE will issue one license for two facilities. Subpart E will explain the methods and standards for establishing payment rates when two or more facilities are merged under one license.

Cost Reports

Providers who have participated in the Medicaid program for 12 months or longer as of December 31 are required to file a calendar year Nursing Facility Financial and Statistical Report (cost report). For facilities that merge under one license, the provider will file one cost report for the facilities for the complete calendar year following the merger and all subsequent calendar years while the facilities remain merged under one license for any portion of the calendar year. The calendar year end cost report will be for 12 months. The cost report will consist of the individual operations of each facility for any part of the calendar year that they operate under separate licenses and the combined operations during any part of the year that they operate under one license. The number of beds, resident days, Medicaid days, and Medicare days will be the total for the facilities merged under one license. All changes in the number of beds during the calendar year will need to be reflected for the merged facilities.

The working trial balances for the merged facilities will need to be combined to fill out the schedules in the cost report. Schedule A, Expense Statement shall reflect the total staff hours and the total direct and in-direct expenditures for the merged facilities. The total revenue and related revenue offsets in Schedule G, Revenue Statement, shall be the total for the merged facilities. For part of the calendar year, the working trial balance may reflect the independent operations for each facility and then following the merger the working trial balance may be consolidated. The working trial balances shall reconcile to the applicable cost report schedules. A schedule that lists all general ledger accounts grouped by cost report line number shall be submitted with the combined cost report.

Rate Determination

Medicaid rates for Kansas NFs and NFs-MH are determined using a prospective, facility-specific rate-setting system. The rate is determined from the base year cost data submitted by the provider. When multiple facilities are joined on one license, the reimbursement rates for each facility will be determined in accordance with the methodology found in Subpart C and as though the facilities remained as separate providers. The only time a new rate will be determined from a combined cost report is